

## SUBCOMMITTEE: SUBCOMMITTEE #1

HOUSE BILL NO. 2798

## AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on

on \_\_\_\_\_)

(Patron Prior to Substitute--Delegate Garrett)

A BILL to amend and reenact §§ 32.1-276.3 and 32.1-276.7:1 of the Code of Virginia, relating to the All-Payer Claims Database; penalty.

**Be it enacted by the General Assembly of Virginia:****1. That §§ 32.1-276.3 and 32.1-276.7:1 of the Code of Virginia are amended and reenacted as follows:****§ 32.1-276.3. Definitions.**

As used in this chapter:

"Actual reimbursement amount" means reimbursement information included in the claims data submitted by data suppliers to the Virginia All-Payer Claims Database, whether such information is referred to in the claims data as "paid amounts," "allowed amounts," or another term having the same or similar meaning and whether in reference to the payer who paid the actual reimbursement amount or the provider who received the actual reimbursement amount.

"Board" means the Board of Health.

"Common data layout" means the national data collection standard adopted and maintained by the APCD Council.

"Consumer" means any person (i) whose occupation is other than the administration of health activities or the provision of health services, (ii) who has no fiduciary obligation to a health care institution or other health agency or to any organization, public or private, whose principal activity is an adjunct to the provision of health services, or (iii) who has no material financial interest in the rendering of health services.

25 "Covered lives" means subscribers, policyholders, members, enrollees, or dependents, as the case  
26 may be, under a policy or contract issued or issued for delivery in Virginia by a managed care health  
27 insurance plan licensee, insurer, health services plan, or preferred provider organization.

28 "ERISA plan" means any self-funded employee welfare benefit plan governed by the requirements  
29 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(1).

30 "Health care provider" means (i) a general hospital, ordinary hospital, outpatient surgical hospital,  
31 nursing home or certified nursing facility licensed or certified pursuant to Article 1 (§ 32.1-123 et seq.) of  
32 Chapter 5 of this title; (ii) a mental or psychiatric hospital licensed pursuant to Article 2 (§ 37.2-403 et  
33 seq.) of Chapter 4 of Title 37.2; (iii) a hospital operated by the Department of Behavioral Health and  
34 Developmental Services; (iv) a hospital operated by the University of Virginia or the Virginia  
35 Commonwealth University Health System Authority; (v) any person licensed to practice medicine or  
36 osteopathy in the Commonwealth pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1; (vi) any  
37 person licensed to furnish health care policies or plans pursuant to Chapter 34 (§ 38.2-3400 et seq.),  
38 Chapter 42 (§ 38.2-4200), or Chapter 43 (§ 38.2-4300) of Title 38.2; or (vii) any person licensed to practice  
39 dentistry pursuant to Chapter 27 (§ 54.1-2700 et seq.) of Title 54.1 who is registered with the Board of  
40 Dentistry as an oral and maxillofacial surgeon and certified by the Board of Dentistry to perform certain  
41 procedures pursuant to § 54.1-2709.1. In no event shall such term be construed to include continuing care  
42 retirement communities which file annual financial reports with the State Corporation Commission  
43 pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 or any nursing care facility of a religious body  
44 which depends upon prayer alone for healing.

45 "Health maintenance organization" means any person who undertakes to provide or to arrange for  
46 one or more health care plans pursuant to Chapter 43 (§ 38.2-4300 et seq.) of Title 38.2.

47 "Inpatient hospital" means a hospital providing inpatient care and licensed pursuant to Article 1 (§  
48 32.1-123 et seq.) of Chapter 5 of this title, a hospital licensed pursuant to Article 2 (§ 37.2-403 et seq.) of  
49 Chapter 4 of Title 37.2, a hospital operated by the Department of Behavioral Health and Developmental  
50 Services for the care and treatment of individuals with mental illness, or a hospital operated by the  
51 University of Virginia or the Virginia Commonwealth University Health System Authority.

52 "Nonprofit organization" means a nonprofit, tax-exempt health data organization with the  
53 characteristics, expertise, and capacity to execute the powers and duties set forth for such entity in this  
54 chapter.

55 "Oral and maxillofacial surgeon" means, for the purposes of this chapter, a person who is licensed  
56 to practice dentistry in Virginia, registered with the Board of Dentistry as an oral and maxillofacial  
57 surgeon, and certified to perform certain procedures pursuant to § 54.1-2709.1.

58 "Oral and maxillofacial surgeon's office" means a place (i) owned or operated by a licensed and  
59 registered oral and maxillofacial surgeon who is certified to perform certain procedures pursuant to § 54.1-  
60 2709.1 or by a group of oral and maxillofacial surgeons, at least one of whom is so certified, practicing in  
61 any legal form whatsoever or by a corporation, partnership, limited liability company or other entity that  
62 employs or engages at least one oral and maxillofacial surgeon who is so certified, and (ii) designed and  
63 equipped for the provision of oral and maxillofacial surgery services to ambulatory patients.

64 "Outpatient surgery" means all surgical procedures performed on an outpatient basis in a general  
65 hospital, ordinary hospital, outpatient surgical hospital or other facility licensed or certified pursuant to  
66 Article 1 (§ 32.1-123 et seq.) of Chapter 5 of this title or in a physician's office or oral and maxillofacial  
67 surgeon's office, as defined above. Outpatient surgery refers only to those surgical procedure groups on  
68 which data are collected by the nonprofit organization as a part of a pilot study.

69 "Physician" means a person licensed to practice medicine or osteopathy in the Commonwealth  
70 pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1.

71 "Physician's office" means a place (i) owned or operated by a licensed physician or group of  
72 physicians practicing in any legal form whatsoever or by a corporation, partnership, limited liability  
73 company or other entity that employs or engages physicians; and (ii) designed and equipped solely for the  
74 provision of fundamental medical care, whether diagnostic, therapeutic, rehabilitative, preventive or  
75 palliative, to ambulatory patients.

76 "Surgical procedure group" means at least five procedure groups, identified by the nonprofit  
77 organization designated pursuant to § 32.1-276.4 in compliance with regulations adopted by the Board,  
78 based on criteria that include, but are not limited to, the frequency with which the procedure is performed,

the clinical severity or intensity, and the perception or probability of risk. The nonprofit organization shall form a technical advisory group consisting of members nominated by its Board of Directors' nominating organizations to assist in selecting surgical procedure groups to recommend to the Board for adoption.

"System" means the Virginia Patient Level Data System.

**§ 32.1-276.7:1. All-Payer Claims Database created; purpose; reporting requirements.**

A. The Virginia All-Payer Claims Database is hereby created to facilitate data-driven, evidence-based improvements in access, quality, and cost of health care and to promote and improve the public health through the understanding of health care expenditure patterns and operation and performance of the health care system.

B. The Commissioner shall ensure that the Department meets the requirements to be a health oversight agency as defined in 45 C.F.R. § 164.501.

C. The Commissioner, in cooperation with the Bureau of Insurance, may shall collect paid claims data for covered benefits, ~~pursuant to data submission and use agreements as specified in subsection C, from entities electing to participate as~~ from data suppliers, which ~~may shall~~ include:

1. Issuers of individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; corporations providing individual or group accident and sickness subscription contracts; and health maintenance organizations providing a health care plan for health care services, for at least 1,000 covered lives in the most recent calendar year;

2. Third-party administrators and any other entities that receive or collect charges, contributions, or premiums for, or adjust or settle health care claims for, at least 1,000 Virginia-residents covered lives on behalf of group health plans other than ERISA plans;

3. Third-party administrators, and any other entities, that receive or collect charges, contributions, or premiums for, or adjust or settle health care claims for, an employer that maintains an ERISA plan that has opted-in to data submission to the All-Payer Claims Database pursuant to subsection P;

4. The Department of Medical Assistance Services with respect to services provided under programs administered pursuant to Titles XIX and XXI of the Social Security Act; and

106 4-5. State government health insurance plans;

107 6. Local government health insurance plans, subject to their ability to provide such data and to the  
108 extent permitted by state and federal law; and

109 7. Federal health insurance plans, if available to the extent permitted by federal law, including but  
110 not limited to Medicare, TRICARE, and the Federal Employees Health Benefits Plan.

111 Such collection of paid claims data for covered benefits shall not include data related to Medigap,  
112 disability income, workers' compensation claims, standard benefits provided by long-term care insurance,  
113 disease specific health insurance, dental or vision claims, or other supplemental health insurance products;

114 ~~C-D.~~ The Commissioner shall ensure that the nonprofit organization executes a standard data  
115 submission and use agreement with each entity listed in subsection B that submits paid claims data to the  
116 All-Payer Claims Database and each entity that subscribes to data products and reports. Such agreements  
117 shall include procedures for submission, collection, aggregation, and distribution of specified data, and  
118 shall provide for, at a minimum: Additionally, the Commissioner shall ensure that the nonprofit  
119 organization:

120 ~~1. Protection of~~ Protects patient privacy and data security pursuant to provisions of this chapter  
121 and state and federal privacy laws, including the federal Health Insurance Portability and Accountability  
122 Act (42 U.S.C. § 1320d et seq., as amended); Titles XIX and XXI of the Social Security Act; § 32.1-  
123 127.1:03; Chapter 6 (§ 38.2-600 et seq.) of Title 38.2; and the Health Information Technology for  
124 Economic and Clinical Health (HITECH) Act, as included in the American Recovery and Reinvestment  
125 Act (P.L. 111-5, 123 Stat. 115) as if the nonprofit organization were covered by such laws;

126 ~~2. Identification of~~ Identifies the type of paid claims to be collected by the All-Payer Claims  
127 Database, and the entities that are subject to the submission of such claims as well as identification of  
128 specific data elements from existing claims systems to be submitted and collected, including but not  
129 limited to patient demographics, diagnosis and procedure codes, provider information, plan payments,  
130 member payment responsibility, and service dates;

131 ~~3. Geographic~~ Administers the All-Payer Claims Database in a manner to allow for geographic,  
132 demographic, economic, and peer group comparisons;

~~4. Identification and comparison of~~ Develops public analyses identifying and comparing health plans by public and private health care purchasers, providers, employers, consumers, health plans, health insurers, and data analysts, health insurers, and providers with regard to their provision of safe, cost-effective, and high-quality health care services;

~~5. Use of existing~~ Uses common data layout or other national data collection standards and methods, ~~including the electronic Uniform Medical Claims Payer Reporting Standard, that utilize a~~ standard set of core data elements for data submissions, as adopted or endorsed by ~~The Accredited Standards Committee X12 (ASC X12) and the~~ APCD Council, to establish and maintain the database in a cost-effective manner and to facilitate uniformity among various all-payer claims databases of other states and specification of data fields to be included in the submitted claims, consistent with such national standards, allowing for exemptions when submitting entities do not collect the specified data or pay on a per-claim basis, such exemption process to be managed by the advisory committee created pursuant to subsection ~~D~~ E;

~~6. Prohibition on disclosure or reporting of~~ Does not disclose or report provider-specific, facility-specific, or carrier-specific reimbursement information, ~~and of or~~ information capable of being reverse-engineered, combined, or otherwise used to calculate or derive such reimbursement information, from the All-Payer Claims Database;

~~7. Responsible~~ Promotes the responsible use of claims data to improve health care value and preserve the integrity and utility of the All-Payer Claims Database; and

~~8. Stipulation~~ Requires that all public reports and analyses comparing providers or health plans using data from the All-Payer Claims Database use national standards; or, when such national standards are unavailable, provide full transparency to providers or health plans of the alternative methodology used.

~~D. E.~~ The Commissioner shall appoint ~~establish~~ an advisory committee to assist in the formation and operation of the All-Payer Claims Database. Such committee shall ~~include a balanced representation of all the stakeholders serving on the governing board of the nonprofit organization as well as individuals with expertise in public health and specific expertise in health care performance measurement and reporting. Each stakeholder on the board of the nonprofit organization shall nominate a member and an~~

~~alternate member to serve on the committee~~ consist of (i) a representative from each of the following: a statewide hospital association, a statewide association of health plans, a professional organization representing physicians, a professional organization representing pharmacists, an organization that processes insurance claims or certain aspects of employee benefits plans for a separate entity, a community mental health center who has experience in behavioral health data collection, a nursing home health care provider who has experience with medical claims data, a nonprofit health insurer, and a for-profit health insurer; (ii) up to two representatives with a demonstrated record of advocating health care issues on behalf of consumers; (iii) two representatives of hospitals or health systems; (iv) an individual with academic experience in health care data and cost-efficiency research; (v) a representative who is not a supplier or broker of health insurance from small employers that purchase group health insurance for employees; (vi) a representative who is not a supplier or broker of health insurance from large employers that purchase health insurance for employees, and (vii) a representative who is not a supplier or broker of health insurance from self-insured employers, all of whom shall be appointed by the Commissioner. The Commissioner, the chairman of the board of directors of the nonprofit organization, the Commissioner of Insurance, the Director of the Department of Medical Assistance Services, the Director of the Department of Human Resource Management, or their designees, shall serve ex officio.

In appointing members to the advisory committee, the Commissioner shall adopt reasonable measures to select representatives in a manner that provides balanced representation within and among the appointments and that any representative appointed is without any actual or apparent conflict of interest, including conflicts of interest created by virtue of the individual's employer's corporate affiliations or ownership interests.

The nonprofit organization shall provide the advisory committee with details at least annually on the use and disclosure of All-Payer Claims Database data, including reports developed by the nonprofit organization; details on methods used to extract, transform, and load data; and efforts to protect patient privacy and data security.

~~The meetings of the advisory committee shall be open to all nominating member organizations and to the public.~~

187 E-F. The Commissioner shall establish a data release committee to review and approve requests  
188 for access to data. The data release committee shall consist of the Commissioner or his designee, and upon  
189 recommendation of the advisory committee, the Commissioner shall appoint an individual with academic  
190 experience in health care data and cost-efficiency research; a representative of a health insurer; a health  
191 care practitioner; a representative from a hospital with a background in administration, analytics, or  
192 research; and a representative with a demonstrated record of advocating health care issues on behalf of  
193 consumers. In making its recommendations, the advisory committee shall adopt reasonable measures to  
194 select representatives in a manner that provides balanced representation within and among the  
195 appointments and that any representative appointed is without any actual or apparent conflict of interest,  
196 including conflicts of interest created by virtue of the individual's employer's corporate affiliations or  
197 ownership interests. The data release committee shall ensure that (i) all data approvals are consistent with  
198 the purposes of the All-Payer Claims Database as provided in subsection A; (ii) all data approvals comply  
199 with applicable state and federal privacy laws and state and federal laws regarding the exchange of price  
200 and cost information to protect the confidentiality of the data and encourage a competitive marketplace  
201 for health care services; and (iii) the level of detail, as provided in subsection H, is appropriate for each  
202 request and is accompanied by a standardized data use agreement.

203 G. The nonprofit organization shall implement the All-Payer Claims Database, consistent with the  
204 provisions of this chapter, to include:

205 1. The reporting of data that can be used to improve public health surveillance and population  
206 health, including reports on (i) injuries; (ii) chronic diseases, including but not limited to asthma, diabetes,  
207 cardiovascular disease, hypertension, arthritis, and cancer; (iii) health conditions of pregnant women,  
208 infants, and children; and (iv) geographic and demographic information for use in community health  
209 assessment, prevention education, and public health improvement. This data shall be developed in a format  
210 that allows comparison of information in the All-Payer Claims Database with other nationwide data  
211 programs and that allows employers to compare their employee health plans statewide and between and  
212 among regions of the Commonwealth and nationally.



2. The reporting of data that payers, providers, and health care purchasers, including employers and consumers, may use to compare quality and efficiency of health care, including development of information on utilization patterns and information that permits comparison of health plans and providers statewide between and among regions of the Commonwealth. The advisory committee created pursuant to subsection ~~D~~ E shall make recommendations to the nonprofit organization on the appropriate level of specificity of reported data in order to protect patient privacy and to accurately attribute services and resource utilization rates to providers.

3. The reporting of data that permits design and evaluation of alternative delivery and payment models.

4. The reporting and release of data consistent with the purposes of the All-Payer Claims Database as set forth in subsection A as determined to be appropriate by the data release committee created pursuant to subsection F.

H. Except as provided in subsection O, the nonprofit organization shall not provide data or access to data without the approval of the data release committee. Upon approval, the nonprofit organization may provide data or access to data at levels of detail that may include (i) aggregate reports, which are defined as data releases with all observation counts greater than 10; (ii) de-identified data sets that meet the standard set forth in 45 C.F.R. § 164.514(a); and (iii) limited data sets that comply with the National Institutes of Health guidelines for release of personal health information.

~~F.~~ I. Reporting of data shall not commence until such data has been processed and verified at levels of accuracy consistent with existing nonprofit organization data standards. Prior to public release of any report specifically naming any provider or payer, or public reports in which an individual provider or payers represents 60 percent or more of the data, the nonprofit organization shall provide affected entities with notice of the pending report and allow for a ~~60-day~~ 30-day period of review to ensure accuracy. During this period, affected entities may seek explanations of results and correction of data that they prove to be inaccurate. The nonprofit organization shall make these corrections prior to any public release of the report. At the end of the review period, upon completion of all necessary corrections, the report may be released. For the purposes of this subsection, "public release" means the release of any report to the general

public and does not include the preparation of reports for, or use of the All-Payer Claims Database by, organizations that have been approved for access by the data release committee and have entered into written agreements with the nonprofit organization.

~~G. The Commissioner and the nonprofit organization shall develop recommendations for elimination of existing state health care data submission and reporting requirements, including those imposed by this chapter, that may be replaced by All-Payer Claims Database submissions and reports. In addition, the~~ J. The Commissioner and the nonprofit organization shall consider and recommend, as appropriate, integration of new data sources into the All-Payer Claims Database, based on the findings and recommendations of the ~~workgroup established pursuant to § 32.1-276.9-1~~ advisory committee.

H-K. Information acquired pursuant to this section shall be confidential and shall be exempt from disclosure by the Virginia Freedom of Information Act (§ 2.2-3700 et seq.). The reporting and release of data pursuant to this section shall comply with all state and federal privacy laws and state and federal laws regarding the exchange of price and cost information to protect the confidentiality of the data and encourage a competitive marketplace for health care services.

I-L. No person shall assess costs or charge a fee to any health care practitioner related to formation or operation of the All-Payer Claims Database. However, a reasonable fee may be charged to health care practitioners who voluntarily ~~subscribe to~~ access the ~~database~~ All-Payer Claims Database for purposes other than data verification.

J-M. As used in this section, "provider" means a hospital or physician as defined in this chapter or any other health care practitioner licensed, certified, or authorized under state law to provide covered services represented in claims reported pursuant to this section.

K-N. ~~The Commissioner, in consultation with the~~ board of directors of the nonprofit organization, shall develop short-term and long-term funding strategies for the ~~creation and operation of the All-Payer Claims Database that may include public and private grant funding, subscriptions for access to data reports, and revenue for specific data projects~~ operation of the All-Payer Claims Database to provide necessary funding in excess of any budget appropriation by the Commonwealth.

266 L. The O. The nonprofit organization, the Department of Health, the Department of Medical  
267 Assistance Services, and the Bureau of Insurance shall have access to data reported by the All-Payer  
268 Claims Database pursuant to this section at no cost for the purposes of public health improvement research  
269 and activities.

270 P. Each employer that maintains an ERISA plan may opt-in to allow a third-party administrator or  
271 other entity to submit data to the All-Payer Claims Database. For any such employer that opts-in, the third-  
272 party administrator or other entity shall (i) submit data for the next reporting period after the opt-in and  
273 all future reporting periods until the employer opts-out and (ii) include data from any such employer as  
274 part of its data submission, if any, otherwise required by this section. Such an employer may opt-out at  
275 any time but shall provide written notice to the third-party administrator or other entity of its decision at  
276 least 30 days prior to the start of the next reporting period. No employer that maintains an ERISA plan  
277 shall be required to opt-in to data submission to the All-Payer Claims Database, and no third-party  
278 administrator or other entity shall be required to submit claims processed before it was contracted to  
279 provide services. Each third-party administrator or other entity providing claim administration services  
280 for an employer shall submit annually to the nonprofit organization by January 31 of each year a list of  
281 the ERISA plans whose employer has opted-in to data submission to the All-Payer Claims Database and  
282 a list identifying all employers that maintain an ERISA plan with Virginia employees for which it provides  
283 claim administration services. Such information submitted shall be considered proprietary and shall be  
284 exempt from disclosure by the Virginia Freedom of Information Act (§ 2.2-3700 et seq.).

285 Q. Any data release shall make use of a masked proxy reimbursement amount, for which the  
286 methodology is publicly available and approved by the data release committee except that the Department  
287 may request that the nonprofit organization generate the following reports based on actual reimbursement  
288 amounts: (i) the total cost burden of a disease, chronic disease, injury, or health condition across the state,  
289 health planning region, health planning district, county, or city, provided that the total cost shall be an  
290 aggregate amount encompassing costs attributable to all data suppliers and not identifying or attributable  
291 to any individual provider, and (ii) any analyses to determine the average reimbursement that is paid for  
292 health care services that may include inpatient and outpatient diagnostic services, surgical services or the

treatment of certain conditions or diseases. Any additional report of analysis based on actual reimbursement amounts shall require the approval of the data release committee.

R. The nonprofit organization shall ensure the timely reporting of information by private data suppliers to meet the requirements of this section. The nonprofit organization shall notify private data suppliers of any applicable reporting deadlines. The nonprofit shall notify, in writing, a private data supplier of a failure to meet a reporting deadline, and that failure to respond within two weeks following receipt of the written notice may result in a penalty. The Board may assess a civil penalty of up to \$1,000 per week per violation, not to exceed a total of \$50,000 per violation, against a private data supplier that fails, within its determination, to make a good faith effort to provide the requested information within two weeks following receipt of the written notice required by this subsection. Civil penalties assessed under this subsection shall be maintained by the Department and used for the ongoing improvement of the All-Payer Claims Database.

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